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REFER TO FILE #

8052

September 5, 2007

T. H. E. Insurance Company
10451 Gulf Boulevard
Treasure Island, Florida 33706
Attn: Ms. Kimberly Boswell

Re: MICHAEL L. DAYTON v. WESLEY GLEN FORT, et al
Index No.: 2007/7091

Dear Ms. Boswell:

Pursuant to your request, enclosed please find a copy of the Summons and Complaint in the above-referenced matter, as well as a copy of the Affidavit of Service for defendant, Albert L. Provost.

Also enclosed, please find a copy of the operative report and various authorizations for the release records from Mr. Dayton's treating medical providers.

Please contact me to discuss this matter once you have had an opportunity to review these items.

Thank you.

Very truly yours,

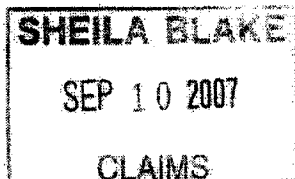
SILVER, FORRESTER, SCHISANO, LESSER & DREYER, P.C.

Michael Forrester

BY: MICHAEL H. FORRESTER, ESQ.

MHF/np

Enclosures



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SAINT FRANCIS HOSPITAL
POUGHKEEPSIE, NEW YORK 12601

OPERATIVE REPORT

PATIENT: DAYTON, MICHAEL MR #: 00-71-34-89
ADMISSION DATE: 06/12/2007 DISCHARGE DATE:
Job #000087322/Doc #374985 P/T:T LOCATION: 5CKE522D
SURGERY DATE: 06/12/2007
PREOPERATIVE DIAGNOSIS: Right open femur fracture.
POSTOPERATIVE DIAGNOSIS: Right open femur fracture.
SURGEON: S. Maurer, MD
ASSISTANT: K. Miller, PA
ANESTHESIA: General
NAME OF OPERATION: Irrigation and debridement and
intramedullary nailing right femur.
ESTIMATED BLOOD LOSS: 100cc -89
FLUID REPLACEMENT: One liter of Crystalloid -89
DRAINS, COMPLICATIONS: None -89
DISPOSITION: The patient to the recovery room in stable
condition.
COMPONENTS IMPLANTED: Stryker T2 nail 420 - millimeter in length x
11 - millimeter in diameter with one
proximal and two distal 5 - millimeter
interlocking screws.

PROCEDURE: The patient was brought to the operating room and general
anesthesia was induced. The patient was given intravenous antibiotics. The
patient was then placed on the fracture table and the fracture was reduced
with a combination of traction and internal rotation with near anatomic
reduction noted with traction. There was noted to be some anterior
displacement of the proximal fragment on the lateral view, which could be
manually reduced. The right lower extremity was then prepped and draped in
the usual sterile fashion. The open wound on the medial aspect of the leg
was opened up with the #10-blade. Right underneath it was noted the
fracture site could be palpated and debridement was performed at this time
including skin, subcutaneous tissue, muscle, and fascia. The fracture site
was then copiously irrigated with pulsatile lavage with nine liters of
fluid. This wound was then left opened.

We directed our attention to the fracture site and using a #10-blade a 2-
centimeter incision was made two finger breaths proximal to the tip of the
greater trochanter. The incision was carried down through the skin and the
subcutaneous tissue. The gluteal fascia was split in line with the

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To: STEPHEN MAURER, MD From: Medical Records

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OPERATIVE REPORT

PATIENT: DAYTON, MICHAEL

MR #: 00-71-34-89

LOCATION: 5CKE522D

previously made skin incision and finger dissection was used to palpate the tip of the greater trochanter. Under fluoroscopic control a threaded guidewire was then advanced to the tip of the greater trochanter and down past the level of the lesser trochanter. The position of the guidewire was checked in AP and lateral fluoroscopic projections. The proximal reamer was then advanced over the guidewire again down to the level of the lesser trochanter. The ball tipped guidewire was then advanced through the pilot hole down to the level of the fracture site and at this time the fracture reduction tool, which was cannulated, was placed over the guidewire again down to the level of the fracture site. The fracture was manipulated with extension of the proximal fragment, which enabled the guidewire to be passed across the fracture site down to the level of the physal scar of the knee. Sequential reaming of the femur was performed at this time beginning with an 8 - millimeter reamer up to a 12.5 - millimeter reamer across the fracture site. The proximal aspect of the fracture, to the level of the lesser trochanter, was reamed to a 14 - millimeter diameter. The guidewire was measured to be 420 - millimeters in length, and at this time an 11 - millimeter in diameter x 420 - millimeter in length T2 nail was assembled on the jig and it was passed across the guidewire, across the fracture site, down to the level of the physal scar of the knee. The guidewire was then removed. One proximal interlocking screw was placed in static mode at the level of the lesser trochanter and using freehand technique two distal interlocking screws were then placed again distally.

Final fluoroscopic x-rays were taken in the AP and lateral fluoroscopic projections, which showed good position of the hardware as well as good reduction of the fracture. The medial wound again was copiously irrigated with pulsatile lavage. The incisions were closed using 0-Vicryl in the fascial layer, 2-0 Vicryl in the subcutaneous tissue, and staples in the skin. Sterile dressings were applied. The patient was then awoken from the anesthesia uneventfully and he was transferred to the stretcher and taken to the recovery room in stable condition. There were no complications. All sponge and needle counts were correct.

SM/cs

D: 06/12/2007 1:15 P

T: 06/14/2007 11:27 A

cc: STEPHEN MAURER, MD
KRISTIN MILLER, PA

STEPHEN MAURER, MD